DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244

HEALTH PLAN BENEFITS GROUP

TO: All Medicare+Choice Organizations (M+COs)

FROM: Gary Bailey, Director

DATE: October 7, 2002

SUBJECT: Payment Validation Contract

In our efforts to be a better business partner, CMS responded to the M+CO community's concern regarding processing of retroactive payments with a two-pronged strategy: 1) eliminate the backlog, and 2) process retroactive adjustments in a timely and consistent manner. Through the use of a contractor, the retroactive adjustments backlog has been significantly reduced. Based on this experience, we decided to contract the processing of all retroactive adjustments, submitted as part of the normal reconciliation process. We believe that this approach will ensure the timeliness and overall consistency with which retroactive adjustments are validated and processed. The process to award the Payment Validation Contract has been ongoing for several months and is now complete.

I am pleased to announce the award of the Payment Validation Contract to IntegriGuard, a Division of CMRI. Under this contract IntegriGuard will validate and process retroactive adjustments for health statuses and demographic data, which was previously handled by the CMS Regional Office Staff. IntegriGuard will begin operations using the processes and procedures as reflected in the Policy Clarification Memo and standard operating procedures, attached. The transition will take place over the next several months as follows:

October 7, 2002
IntegriGuard will begin to accept requests directly from the MCOs for retroactive adjustments related to State and County Code and Institutional Health Statuses.

November 1, 2002
IntegriGuard will begin to accept requests directly from the MCOs for retroactive adjustments related to Medicaid.

December 1, 2002
IntegriGuard will begin to accept requests for retroactive adjustments related to ESRD and Working Aged.

Retroactive Enrollments and Disenrollments will be transferred to IntegriGuard. However the dates for this transition have not been finalized. I will keep you informed as this aspect of the transition solidifies.

Please mail your retroactive adjustment requests, using the instructions attached to:

Payment Validation Project
10040 Regency Circle, Suite 260
Omaha, Nebraska 68114

If you have any questions regarding this transition, do not hesitate to contact Marla Kilbourne at 410-786-7622 Mkilbourne@cms.hhs.gov or Carol Eaton at 410-786-6165 Ceaton@cms.hhs.gov

Attachments:
A. Retroactive Payment Adjustment Policy Clarification
B. Integriguard Submission process
C. SOP for State and County Code Adjustments
D. Processing of Institutional Adjustments
E. SOP for Medicaid Adjustments
F. End Stage Renal Disease Retroactive Adjustments
G. Processing of Working Aged Retroactive Adjustments

Tab A

Retroactive Payment Adjustment Policy Clarification

These instructions provide guidance on the processing of retroactive payment adjustments. These adjustments occur due to evidence that the original payment was based on erroneous information about the following beneficiary demographic characteristics: age, sex, Part A and/or Part B coverage, enrollee's county of residence, Medicaid status, institutional status, working aged status, hospice election and ESRD status.

In **OPLs 95.012 and 95.013,** CMS established policy allowing health maintenance organizations/competitive medical plans (HMOs/CMPs) with risk contracts to request retroactive adjustment of certain membership records. With the passage of the Balanced Budget Act (BBA), CMS extended this policy to Medicare +Choice organizations (M+COs).

NOTE: The final section of this letter addresses retroactive enrollment/disenrollment processing. The 36-month limit does not apply to these enrollments/disenrollments.

Receipt of Data

There are two definitions of "receipt of data" depending on the category of the adjustment and the way the change is received.

1. "Receipt of data" means the date cms or its agent receives documentation. The date CMS receives from the M+CO **complete documentation supporting the correction** request is the date used to define the retroactive payment period.

   Demographic characteristics included under this definition are institutional, Medicaid (submitted by the MCO), and state and county of residence.

   The 36-month retroactive start date begins the first of the month the documentation was received from the M+CO. It is possible in some situations, this timeframe will be greater than 36 months from the current payment month by the time the request is processed. Should this occur, CMS will use the override option.

2. "Receipt of data" means system interface date. The date that status corrections are received in the Group Health Plan (GHP) system from the source systems (i.e., the Social Security Administration, ESRD system, the Enrollment Database and the Common Working File) is the date used to apply the retroactive payment period.

   Demographic characteristics included under this definition are age, sex, residence state and county code, Part A and B coverage, hospice, Medicaid, ESRD and working aged status corrections.

   During processing, the GHP will automatically apply the 36-month retroactive payment period back from the date the correction was received by the GHP, but will record the actual effective start and end dates of the changed status correction.

Retroactive Demographic Adjustments

Retroactive adjustments may be created based on changes to the demographic characteristics of the members of an M+CO. The demographic characteristics of an enrollee include the following:

Age
Sex
Enrollee's County of Residence
Hospice Election
ESRD Status
Working Aged Status
Institutional Status
Medicaid Status
Coverage Under Part A (for remaining Part B only enrollees)

The retroactive payment period is limited to 36 months which begins as defined by the "receipt of data" definition applicable to the characteristic being adjusted.

The following table defines the retroactive payment period for each demographic characteristic.

CHARACTERISTIC	WHO ADJUSTS	TIMEFRAME 36 months from the …
Age	SSA thru EDB	Date GHP is updated
Sex	SSA thru EDB	Date GHP is updated
Part A/B	SSA thru EDB	Date GHP is updated
State and County Code	SSA thru EDB	Date GHP is updated
	Retro-Processing Contractor thru McCOY	Date documentation is received by RO
Hospice	CWF thru the EDB	Date GHP is updated
ESRD	ESRD system thru EDB*	Date GHP is updated
Working aged	CWF thru the EDB**	Date GHP is updated
Institutional	Retro-Processing Contractor thru MCCOY	Date documentation is received by RO
Medicaid	State buy-in system	Date GHP is updated
	Retro-Processing Contractor thru MCCOY	Date documentation is received RO

*- ROs instruct M+COs to obtain completed 2728 forms from the dialysis centers and to send them to central office. CO works with OCSQ staff to correct ESRD system.

** - M+COs are instructed to submit normal corrections to GHP and to send problem cases with documentation to the COB contractor.

***- The hierarchy of the status adjustments are applied as follows: Hospice, ESRD, Working Aged, Institutional, Medicaid.

If more than one status applies the payment will be calculated using the status in descending order.

Retroactive Election (Enroll/Disenroll) Changes

Detailed instructions governing the processing of retroactive enrollments/disenrollments are contained in OPL 100. When CMS determines that an election should be retroactive, the payment or recoupment period corresponds directly with the length of the enrollment period. This is true even if the 36-month period would be exceeded. In addition, if the BBA election limits would be exceeded, the RO should process the election as a SEP.

Retroactive Enrollment

CMS-approved retroactive enrollments are made back to the statutorily required effective date if the beneficiary meets all eligibility requirements.

If the 36-month timeframe would be exceeded, the RO will use the overide option to allow complete payment to the M+CO.

Retroactive Disenrollment

CMS-approved retroactive disenrollments are made back to the statutorily required effective date. If the 36-month timeframe would be exceeded, the RO would use the override option to allow complete recoupment of funds from the M+CO.

Tab B

INTEGRIGUARD SUBMISSION PROCESS FOR M+COS

October 7, 2002, IntegriGuard will begin processing adjustments for the state and county code (SCC) and institutional (INST) health status categories for the Centers for Medicare and Medicaid Services (CMS).

M+COs can submit requests to IntegriGuard on CD, diskette, or paper. The specific format and required fields for submission of state and county code and institutional changes is shown below, however, M+COs may submit the information for either category using an Excel spreadsheet, a Word document, or an Access database. **Please note that this information cannot be sent by fax or e-mail as required under HIPAA regulations.** In addition, a cover letter including the M+CO number (H#) and certification must be submitted along with the requested changes. The appropriate language for the certification is as follows:

> "This signature verifies that the information submitted to IntegriGuard on __(date)_ is accurate and complete and that supporting documentation is being maintained at the M+CO for each request."

The original supporting documentation for the requested changes must be retained by the M+CO.

Submitting State and County Code Status Changes

The M+COs will submit their requested changes to IntegriGuard. IntegriGuard will acknowledge receipt of the requested adjustments within 10 days of receipt. This may be done via mail, e-mail or telephone. Requested changes will be processed within 45 days of receipt. Upon completion of processing, IntegriGuard will provide the M+CO with a report detailing the disposition of the requests, including an explanation of reasons for not entering the change as submitted into the system. Supporting documentation will be required only as requested by IntegriGuard in conjunction with or as a result of the probe study. (See section titled "Probe Study").

The required information and specific column order needed to process each state and county code change is as follows:

M+CO Name **Contact Name:**
Mailing Address **Phone #:**
City, State, Zip Code **E-Mail Address:**

					SCC			
H#	**CMS Region #**	**HIC #**	**Beneficiary's Last Name**	**Beneficiary's First Name**	**Start Date mm/dd/yyyy**	**End Date mm/dd/yyyy**	**Req SCC**	**Req Zip Code**

Please note: All fields must be completed. If the M+CO does not have the end date because the beneficiary still resides in the SCC requested, please place "N/A" in the end date field. Also, please enter dates as mm/dd/yyyy (example, 01/01/2002).

Submitting Institutional Status Changes

The M+COs will submit their requested changes to IntegriGuard. IntegriGuard will acknowledge receipt of the requested adjustments within 10 days of receipt. This may be done via mail, e-mail or telephone. Requested changes will be processed within 45 days of receipt. Upon completion of processing, IntegriGuard will provide the M+CO with a report detailing the disposition of the requests, including an explanation of reasons for not entering the change as submitted into the system. Supporting documentation will be required only as requested by IntegriGuard in conjunction with or as a result of the probe study. (See section titled "Probe Study").

The required information and specific column order needed to process each institutional status change is as follows:

M+CO Name **Contact Name:**
Mailing Address **Phone #:**
City, State, Zip Code **E-Mail Address:**

					INST		
H#	CMS Region #	HIC #	Beneficiary's Last Name	Beneficiary's First Name	INST Start Date mm/dd/yyyy	INST End Date mm/dd/yyyy	Month(s) Requested

Please note: All fields must be completed. If the M+CO does not have an end date because the beneficiary still resides in the institution, please place "N/A" in the end date field. The month(s) requested field is defined as the month(s) for which the M+CO is requesting institutional payment.

Probe Study

In order to assure appropriate oversight, IntegriGuard will periodically conduct a probe study by requesting supporting documentation from various M+COs. The purpose of this study is to review and verify that appropriate documentation is maintained by the M+COs as defined in the CMS Standard Operating Procedures (SOP).

A 5% random sample of M+CO status changes will be chosen for inclusion in the study. When an M+CO is notified of inclusion in the probe study, the M+CO will have 7 business days from the date of M+CO receipt of IntegriGuard's request to submit supporting documentation. At a minimum the request for documentation will include the H#, HIC#, and the specific adjustment being reviewed. After review of the documentation, IntegriGuard will send the M+CO a report of the findings, including disposition. If the documentation is not received or does not support the requested changes, the changes will be nullified.

A report will be sent to CMS including the specific results of the Probe Study and a recommendation concerning the M+CO's future submission requirements. IntegriGuard may recommend validation of adjustments previously submitted and entered into the Managed Care payment systems.

Submission Address

Please send all payment adjustment requests for changes to state and county code and institutional enrollment status categories to:

IntegriGuard
MMC Enrollment Project
10040 Regency Circle, Suite 260
Omaha, Nebraska 68114

Tab C

STANDARD OPERATING PROCEDURES FOR STATE AND COUNTY CODE ADJUSTMENTS

State and County Code Description

Beneficiaries' state and county of residence have a direct effect on the capitation rate regardless of health status. The source of the state and county code of residence is the Social Security Administration.

General Information about the State and County Code Designation and its Effect on M+CO Payments

The beneficiary's state and county code is transmitted from Social Security Administration (SSA) to the CMS managed care payment systems (Group Health Plan master/McCoy) via the Enrollment Database (EDB). The SSA systems interface with the CMS' systems daily. The managed care system accepts and updates the state and county code information on managed care beneficiaries that it receives from SSA. The CMS regional offices can update a beneficiary's SCC information in McCoy and block the update from the EDB. If an SCC has been updated in McCoy, the GHP will compare the zip code information with the new information coming from the EDB before updating the SCC. (If the Retro-Processing Contractor used the SCC exception to prevent an update, the GHP compares the address in the M+CO file with the address in the SSA file. If the entire zip code has changed from the previous zip code obtained from the SSA file then the block is automatically cancelled and SSA information is placed in the file as a real update).

General Guidelines for M+COs requesting retroactive adjustments

The M+CO should submit requests for adjustments within 45 days of receiving their monthly reports from CMS. The M+CO may request a retroactive adjustment changing the state and county code when the beneficiary's state and county code included in the monthly membership report is different from the state and county of residence the M+CO has on file for that beneficiary. The M+CO would identify this during the normal monthly reconciliation process of comparing the Monthly Membership report and Transaction Reply report with the M+CO's records.

Before submitting the requests to the Retro-Processing Contractor to retroactively adjust the SCC, the M+CO must complete the following actions:

> Notify the beneficiary that the residence SCC information given to the M+CO differs from the residence SCC information on record with the Social Security Administration.
>
> Request the beneficiary notify SSA of his/her current residence address by calling the SSA 800 number. ((800) 772-1213). If the residence address is different from their mailing address, they should notify SSA of both addresses.

M+COs must obtain documentation verifying the residence information the M+CO has in their records.

A SCC adjustment will be made retroactively for the dates requested, however, payment will be made for no more than 36 months from the date the request is received by the Retro-Processing Contractor.

The M+CO should never submit duplicate information unless the CMS central office, Regional Office or the Retro-Processing Contractor specifically requests the duplicate information be submitted.

To follow up on specific previously submitted adjustments, a letter of inquiry should be sent separately from other adjustment requests. It should clearly state in the subject line that it is a follow-up to request(s) previously submitted. The letter must include the claim number of the individual, the state and county code, the period involved and the date the original adjustment(s) was submitted.

Documentation Required to Retroactively Change a Beneficiary's State and County Code

M+CO Contract Number (H#)

Beneficiary Name and Claim Number

Verification of Residence including starting/ending dates:

One or more of the following constitutes acceptable documentation :

- -Survey signed by the beneficiary (sample attached)
- -Copy of property tax statement
- -Copy of income tax return
- -Copy of voter's registration card
- -Copy of a utility bill
- -Document showing the address and county from an internet mapping utility which is based on the U.S. Postal service data (i.e. Mapquest, Mapblast)

Retro-Processing Contractor Review and Processing of the Request

The Retro-Processing Contractor will acknowledge receipt of the request for retroactive adjustments within 10 days of receipt. The Retro-Processing Contractor will process requested adjustments within 45 days of receipt, or return it to the M+CO including the reason that the adjustment was not processed.

The Retro-Processing Contractor will return the request without action if the documentation is not complete.

The Retro-Processing Contractor will return the request without action if none of the dates of the revised state and county codes are within the 36 months prior to the request.
The Retro-Processing Contractor will return the request without action if the beneficiary was not a member of the plan for the discrepancy period.

The Retro-Processing Contractor will validate the requested change and then enter the revised SCC information into McCOY. **The Retro-Processing Contractor may have to correct all the information or just the effective date of the SCC.** The Retro-Processing Contractor may have to correct previous SCC information to effect the necessary changes.

When the transaction has been completed it will appear on the M+CO's next Transaction Reply Report and Monthly Membership Report.

RESIDENCE VERIFICATION FORM
Name _____
Medicare Claim Number _____

Current residence address (where you live)
Street _____
City, State, Zip _____
County _____
Current Phone Number _____

When did you move to this address? DATE (month and year)_____

Is this move permanent? YES NO

If the address shown above isn't permanent, what is your permanent address?
Street _____
City, State, Zip_____
County _____

When is your expected return to permanent address? DATE (month and year)_____

Does your mail go to a different address? YES NO
If yes, please show that address
Street/Post Office Box _____
City, State, Zip _____

Reason for different residence and mailing addresses:
_____
Member Signature _____
Date _____

M+CO Name _____

Tab D

STANDARD OPERATING PROCEDURES FOR PROCESSING OF INSTITUTIONAL ADJUSTMENTS

Institutional Description:

Institutional refers to a health status that is attributed to a beneficiary who is a resident in an institution or distinct part of an institution that has been certified by Medicare. This health status can only be assigned after they have been a resident of a certified institution for a qualifying period. (The definition of certified institution can be found in Sections 170 and 170.1 of Chapter 7 of the Medicare Managed Care Manual). The beneficiary is not required to be a member of the M+CO nor Medicare during the qualifying period.

General Information about institutional payments:

The institutional rate is paid retroactively for those members that meet the criteria for the institutional rate. For the M+CO to be eligible to receive payment at the institutional rate, the beneficiary must have been a resident in a Medicare certified institution for a 30-day period including the last day of that month. This is referred to as the "qualifying period". Additionally, the beneficiary must be living and enrolled in the M+CO the first day of the following month. Once the M+CO has verified that a beneficiary has met the criteria, including both the qualifying period and enrollment requirements, the M+CO may request they be paid the institutional rate for that beneficiary for the month following the qualifying period.

The qualifying period must be 30 consecutive days that includes the last day of that month. The M+CO does not get the institutional rate for the qualifying period; rather they receive the institutional rate for the month following the qualifying period. If a beneficiary resides in a Medicare Certified Institution from April 1 to April 30, then the M+CO will receive the institutional rate for that beneficiary for the month of May.

In our example the beneficiary must remain enrolled in the M+CO the first day of May for the plan to receive any payments for this beneficiary, including the institutional rate adjustment.

The normal method for M+COs to request the institutional rate for beneficiaries requires the M+CO to submit electronic records, transaction type "01" to be included in the normal batch processing done by CMS. Each beneficiary record must include the claim number, the beneficiary name, action code "D", the M+CO's contract number (HXXXX) and the transaction code "01". The correct layout is found in the Plan Communications Guide. These transactions will be processed during the normal monthly processing for payments, so they must be received by the established cut-off dates indicated on the GHP monthly schedule. These transactions effect payment related to the previous month (e.g. only April's qualifying period for May 1 payment can be submitted by the May cut-off). If for any reason the entire electronic submission is not processed during the normal period, the M+CO should contact the Retro-Processing Contractor for assistance. The Plan Communication Guide provides the specific directions for the M+CO process.

The following are examples of common situations that are likely to be encountered.

- Example 1:
  Institutionalized on February 14. Resided in the institution on March 31.
  Enrolled in the plan on April 1.
  The qualifying period: March 1 - March 31
  Institutional payment allowed: April 1 – April 30
  M+CO submits the beneficiary information electronically to CMS by April cut off.
  The May monthly payment will include the institutional adjustment for April.

  Note: The beneficiary could have been, but did not need to be enrolled in the M+CO or in Medicare during the qualifying period.

CMS will continue to pay the institutionalized rate while an enrolled member is temporarily absent from the facility for hospitalization or therapeutic leave, if the member returns to a certified institution, or distinct part of an institution, as defined in Chapter 7 of the Medicare Managed Care Manual. Temporary absences (less than 15 days) for medical necessity will be counted toward the 30-day requirement. Absences totaling 15 days or more during a month ends the institutional stay and the qualifying period of 30 days, including the last day of the month must be met before institutional status can be reinstated.

- Example 2:
  Beneficiary is absent from the institution January 1 through January 4 AND
  Beneficiary is absent from the institution January 10 through January 20
  The temporary absence is 15 days, which totals more than 14 days in the month
  The M+CO is not eligible to receive the institutional rate for this beneficiary.
  The qualifying period must be met before the institutional rate can begin.

- Example 3:
  Institutionalized on September 16 through November 29
  Beneficiary is temporarily absent (hospitalized) from October 5-21.
  The beneficiary did not meet the qualifying period in October because the beneficiary was absent from the institution for more than 14 days during October.
  The beneficiary did not meet the qualifying period for November because the beneficiary did not remain in the institution the last day of November.
  The M+CO is not eligible to receive the institutional rate because the beneficiary did not meet the 30-day qualifying period.

- Example 4:
  Institutionalized on January 7, hospitalized on February 15-27. Returns to the institution.
  Enrolled in the plan on March 1.
  The beneficiary was absent from the institution for 13 days during February.
  The qualifying period was January 29 - February 28
  Institutional payment allowed: March 1 - March 30
  M+CO submits the beneficiary electronically to the CMS.
  The April monthly payment will include the institutional payment adjustment for March.

General Guidelines for M+COs requesting institutional adjustments for other than the preceding month.

It is the M+CO's responsibility to verify whether a beneficiary has met the criteria for institutional status and to submit the required documentation to the Retro-Processing Contractor within 45 days of the monthly reports in becoming available via Grouch to the M+COs.

The M+CO may submit requests for the institutional rate for periods other than the preceding month including both a single month and multiple months. The Retro-Processing Contractor will review the request and may make the change in status directly in McCoy. The retroactive adjustments will be processed in the next normal payment cycle.

If the documentation submitted by the M+CO is incomplete, it will be returned without action.

The M+CO should never submit duplicate information unless the CMS Central Office, Regional Office or Retro-Processing Contractor specifically requests that the duplicate information be submitted.

If the M+CO is following up on specific previously submitted adjustments, the letter of inquiry should be sent separately from other adjustments and clearly indicate that it is a follow-up to request(s) previously submitted. It must include the claim number of the individual, the period involved, and the date the original request(s) was submitted.

Documentation Required by the Retro-Processing Contractor to Change the Institutional Health Status Retroactively

M+CO Contract Number (H#)

Beneficiary Name and Claim Number

Period that the Beneficiary resided at the Institution

Months to be affected for institutional payment by this request

Periods of Absence from the institution, including attestation that it was for hospitalization or therapeutic reasons.

Verification of the institutional stay including:

- The name of the facility
- The date the verification with the facility was accomplished by the M+CO
- The name and phone number (or e-mail/fax) of the person who was contacted at facility
- The name of the person who did the verification at the M+CO

Attestation that the facility is certified and the member resided in a certified part of the facility. (The M+CO does not have to provide the certification number but should assure the certification documentation to support this attestation is available upon request).

Retro Processing Contractor Review and Processing of the Institutional Status Request

The Retro-Processing Contractor will acknowledge receipt of the request for retroactive adjustments within 10 days of receipt. The Retro-Processing Contractor will process requested adjustments within 45 days of receipt, or return it to the M+CO including the reason that the adjustment was not processed.

The Retro-Processing Contractor will return the request without action, if the documentation is not complete.

The Retro-Processing Contractor will return the request without action if none of the dates of institutional residence are within the 36 months prior to the request.

The Retro-Processing Contractor will return the request without action if the total days of temporary absence were 15 days or more, during the period for which institutional status is requested.

The Retro-Processing Contractor will return the request without action if the beneficiary was not a member of the plan for the period the institutional payment rate is requested.

If the institutional period requested in the adjustment request reflects the institutional period already in McCoy, it will be returned it to the M+CO without action.

The Retro-Processing Contractor will validate the requested change and enter the period that the M+CO will receive the institutional capitation rate for that beneficiary into McCOY. Note that the M+CO does not receive the increased capitation rate for the qualifying period and that the start date should always be the first day of the month following the month during which the qualifying period ended.

Adjustments to the payment will be made during the 45 days following receipt of the requested adjustment. Payment will be processed in accordance with the normal GHP cut-off cycles.

The following are examples of common situations that are likely to be encountered.

- Example 6:
  Institutionalized on January 7, hospitalized on February 14-27.
  Discharged from the institution on May 13.

  The qualifying period: January 30 - February 28 institutional stay (Temporary absence was less than 15 days)
  Institutional Payment allowed: March 1 - March 31

Qualifying Period: March 1 to March 30
Institutional payment allowed: April 1 - April 30

Qualifying Period: April 1 to April 30
Institutional Payment allowed: May 1 - May 31

The payment for the entire period is entered in McCoy as "Start 3/01/YYYY and End 05/31/YYYY."

- Example 7:
  Institutionalized on June 6. Died on November 13.
  The qualifying period: July 1- July 31
  Institutional payment allowed: August 1 - August 31

  The qualifying period: August 1 - August 31
  Institutional payment allowed: September 1 - September 30

  The qualifying period: September 1 - September 30
  Institutional payment allowed: October 1 - October 31

  The qualifying period: October 1 - October 31
  Institutional payment allowed: November 1 - November 30

  The payment for the entire period is entered in McCoy as "Start 08/01/YYYY and End 11/30/YYYY"

Although the member died the middle of the month, the M+CO would not receive the institutional rate due to death. The member was not enrolled in the M+CO the first day of December.

Tab E

STANDARD OPERATING PROCEDURES FOR MEDICAID RETROACTIVE ADJUSTMENTS

Medicaid Description

Medicaid is a Federal and State program that provides medical services to clients of state public assistance programs. Medicaid eligibility is determined by the state Medicaid agency in the state where the beneficiary resides. Some Medicare beneficiaries are also eligible for Medicaid. These individuals are commonly referred to as Dual Eligible beneficiaries. The Centers for Medicare and Medicaid Services (CMS) administers the federal standards compliance aspects of this program and monitors the federal payments related to the Medicaid Program for both Medicaid only and the dually eligible population. The law requires that all states pay the Part B premium to Medicare for dual eligible beneficiaries. The law does not require states to pay the Part B premium for individuals who are classified as Medical Assistance Only (MAO) even though the increased capitation rate applies, however many states have elected to report these individuals as dually eligible and pay their Part B premium.

General Information about Medicaid Payments

In accordance with the Health Status hierarchy (Hospice, ESRD, Working Aged, Institutional, **Medicaid**), M+COs receive a higher capitation rate for Medicare beneficiaries who have been identified as Medicaid in the CMS systems.

The primary source of this information is the Third Party Master Premium Billing system (TPM), which is used by CMS to bill states for the Part B premiums paid by states on behalf of dually eligible individuals. All states report data in this system as all states pay the Part B premium for their dual eligibles (with the exception of MAOs in some states). This is the source data used by the managed care payment system (Group Health Plan system (GHP)) to identify the dually eligible beneficiaries that have Medicaid status. The M+COs are required to rely on the data from the TPM billing system for this portion of the population. The TPM records this transaction. The GHP system then interfaces monthly with the TPM and updates its files to reflect any new information. This process may effect payments prospectively and retroactively. The M+CO should notify the state office responsible for updating the CMS Third Party Billing system when discrepancies are identified for dually eligible individuals.

Guidelines for Prospective Medicaid Adjustments

M+COs can identify beneficiaries as Medicaid in certain instances, for prospective payments only. Primarily this is to place individuals who are classified as Medical Assistance Only (MAOs) in a Medicaid status, but are not limited to this category. These prospective payments are submitted to CMS during the normal monthly process. M+COs need only report the MAO status for members who reside in the states that do not report these individuals. All other dually eligible beneficiaries are reported to CMS via the TPM update process. The states that do not pay the premium for MAO individuals are:

Connecticut	Minnesota	Pennsylvania
Delaware	Missouri	Rhode Island
Idaho	Montana	South Dakota
Illinois	Nebraska	Tennessee
Kentucky	New Hampshire	Texas
Louisiana	New York	Vermont
Maine	North Dakota	Virgin Islands
Massachusetts	Oklahoma	West Virgina
		Wisconsin

General Guidelines for M+COs requesting retroactive adjustments

The M+CO should submit requests for adjustments to the regional office within 45 days of identifying the discrepancy during the normal monthly reconciliation of the CMS Monthly Membership report against the M+CO's records.

The M+CO may request a retroactive adjustment either placing a beneficiary into the Medicaid health status or removing the beneficiary from the Medicaid health status.
The M+CO should never submit duplicate information unless the CMS Central Office or Regional Office specifically requests that duplicate information be submitted.

To follow up on specific previously submitted requests for adjustments, a letter of inquiry should be sent separately from other requests for adjustments. It should clearly state in the subject line that it is a follow-up to request(s) previously submitted. The letter must include the claim number of the individual, specific action requested, the discrepancy period involved and the date the original request(s) was submitted.

If the package submitted to CMS is incomplete, it will be returned to the M+CO for completion. No action will be taken on the package until the complete documentation is received.

Retroactive Medicaid adjustments will be made for the dates requested, however, payment will be made for no more than 36 months from the date the complete documentation is received in the RO.

Documentation required to retroactively change the Medicaid health status of a beneficiary:

M+CO Contract Number (H#)

Beneficiary Name and Claim Number

Verification of Medicaid Status including starting/ending dates.

One or more of the following constitutes acceptable documentation:

A copy of the Medicaid card documentation that the M+CO verified Medicaid eligibility with the state including:
The date of the verification call by the M+CO
The phone number used to verify eligibility
The name of the state staff person who verified the Medicaid period
A copy of the state document that confirms Medicaid entitlement for the discrepant period.
A screen print from the State's Medicaid System that shows the Medicaid status for the discrepant period.

If a vendor provides the required information to request a change in the Medicaid status, the M+CO must submit a document from that state authorizing the use of the vendor as a valid source for Medicaid information.

Regional Office Review and Processing of the Request

The Retro-Processing Contractor will acknowledge receipt of the request for retroactive adjustments within 10 days of receipt. The Retro-Processing Contractor will process requested adjustments within 45 days of receipt, or return it to the M+CO including the reason that the adjustment was not processed.

The Retro-Processing Contractor will return the request without action, if the documentation is not complete.

The Retro-Processing Contractor will return the request without action if the dates of Medicaid status are older than 36 months prior to the receipt of the request by the RO.

The Retro-Processing Contractor will return the request without action if the beneficiary was not a member of the plan for the discrepancy period.

If the Medicaid status for the period requested in the adjustment reflects the current Medicaid periods in GHP, return it to the M+CO without action.

If not, the Retro-Processing Contractor will validate the requested change and enter the revised Medicaid status into McCOY.

Tab F

STANDARD OPERATING PROCEDURES FOR END STAGE RENAL DISEASE RETROACTIVE ADJUSTMENTS

ESRD Description:

A beneficiary receives the End Stage Renal Disease (ESRD) status when a physician prescribes a regular course of dialysis because the member has reached that stage of renal impairment that a kidney transplant or a regular course of dialysis is necessary to maintain life. Medicare will pay the M+CO at the higher, ESRD capitation rate for that beneficiary (unless they have elected hospice care).

General Information about the ESRD payments:

Payments made based on the ESRD health status are paid prospectively. The process of passing the information through the various databases may take as long as four full months from the time a beneficiary is identified by the physician as having ESRD. Therefore, the M+CO may not begin receiving the ESRD capitation rate for the beneficiary for at least 4 months.

When the health status is included in the capitation rate for the beneficiary who is already in Medicare, the managed care payment system will automatically pay retroactively to include the first month of ESRD health status within 36 months. However, if the beneficiary is entitled to Medicare as a result of ESRD, there is a 3-month waiting period before Medicare entitlement will begin. The Renal Beneficiary Utilization (REBUS) system will automatically adjust for this requirement and M+COs receive payment at the ESRD capitation rate of pay. The health status is based on the first date of dialysis as indicated on the End Stage Renal Disease Medical Evidence Report Medicare Entitlement and/or Patient Registration (form HCFA-2728). In addition, the physician's signature and signature date must be clearly legible before the Renal Networks can enter any information in the Standard Information Management System (SIMS) Although, Managed Care staff at the Retro-Processing Contractor, Regional Office or Central Office cannot enter ESRD status changes/corrections into the GHP managed care system, they can resync the GHP to the EDB if the systems' data do not match. This process may result in a change in the ESRD status and the associated positive or negative payment. The Renal Networks enter the data from the HCFA 2728, which is transmitted, to the CMS systems through an automated process. The HCFA 2728 is the key source of documentation to ensure that a beneficiary will be identified with the ESRD health status indicator and must be completed within 45 days of beginning a regular course of dialysis or receiving a kidney transplant, which was prescribed by a physician.

- The ESRD facility forwards a copy of the HCFA-2728 to its local Social Security Administration (SSA) Field Office and to its respective ESRD Renal Network organization.

- For individuals diagnosed with ESRD, the SSA determines eligibility for the Medicare ESRD entitlement based on HCFA-2728 under the end stage renal disease provisions of the law.

- The Renal Network organization inputs the information into its data system, and transmits the information to CMS, Office of Clinical Standards and Quality (OCSQ).

- CMS, Office of Clinical Standards and Quality (OCSQ), updates the information in the (REBUS). REBUS is CMS' central repository for beneficiaries with ESRD.

- Daily, REBUS updates the Enrollment Database (EDB) with ESRD health status start and/or ends dates.

- Monthly, the EDB updates the Group Health Plan (GHP) system with ESRD health status start and/or end dates for the M+CO member. The GHP managed care enrollment and payment system is the source of information used in computing the monthly capitation rates that the M+COs receive.

General Guidelines for M+COs requesting ESRD retroactive adjustments

The M+CO may request a retroactive adjustment payment at the ESRD capitation rate when the M+CO has received erroneous payment at the non-ESRD capitation rate for a Medicare beneficiary who is currently receiving maintenance dialysis treatments or has had a successful kidney transplant within the last 36 months. The M+CO identifies this during the normal monthly reconciliation of the Monthly Membership report, received from CMS, against their own records. (Usually the M+COs work along with their medical management department to determine which members are currently receiving dialysis treatment or are within 3 years following a transplant). By doing this, the M+CO is able to determine whether they should be receiving the ESRD capitation rate of payment.

The M+CO must wait at least four months from the date the HCFA-2728 form was signed by the physician to allow for the normal processing of the data before submitting a request for retroactive adjustment.

In order to determine when an update will be posted to the GHP, note the "Plan Data Due" dates on the GHP Monthly schedule. If corrections are entered in the system prior to this date then payment will be made the following month. However if corrections to the beneficiary's record are after this date, payment will be the month following the next payment month. Keep in mind; the above is based on each system being updated timely. The GHP Monthly schedule is produced annually by staff in the Division of Program Accountability and Payment and is distributed to all M+COs and Retro-Processing Contractor contacts. A copy of the schedule is also a part of the Plan Communications Guide located at http://cms.hhs.gov/healthplans/systems/Guides.asp

The M+CO may contact the appropriate Renal Network to verify specific data related to the discrepancy. The Renal Network will only supply the following information:

1) The first date of dialysis or date of transplant, and
2) Date the beneficiary's HCFA 2728 was submitted to CMS by the Renal Network
3) Current Renal Status (this information is not required for a retroactive adjustment)

The M+CO should never submit duplicate information unless the CMS Central Office, Regional Office, or Retro-Processing Contractor specifically requests that the duplicate information be submitted.

To follow up on specific previously submitted adjustments, a letter of inquiry should be sent separately from other adjustments. It should clearly state in the subject line that it is a follow-up to request(s) previously submitted. The letter must include the claim number of the individual, the health status, the period involved and the date the original adjustment(s) was submitted.

If the package requesting the retroactive adjustment is not in accordance with the instructions from the Retro-Processing Contractor, it will be returned to the M+CO without action.

Documentation required to retroactively place a beneficiary in ESRD status.

M+CO Contract Number (H#)

Beneficiary Name and Health Insurance Claim Number

First date of dialysis or transplant date

Date Enrolled in M+CO

Specific discrepancy period that the M+CO is requesting the change to ESRD health status.

Copy of the HCFA-2728 form, if there is no period of ESRD established. (The M+CO must request a copy of the HCFA-2728 from the dialysis facility NOT from the Renal Network organization.)

Date HCFA 2728 was originally sent to CMS

Retro-Processing Contractor Review and Processing of ESRD the Request

Effective December 1, 2002, the Retro-Processing Contractor will acknowledge receipt of the request for retroactive adjustments within 10 days of receipt. The Retro-Processing Contractor will process requested adjustments within 45 days of receipt, or return it to the M+CO including the reason that the adjustment was not processed.

The Retro-Processing Contractor will return the request to the M+CO without action if there have not been at least 4 months since the beneficiary began dialysis as a Medicare beneficiary.

The Retro-Processing Contractor will return the request to the M+CO without action if all required information has not been submitted.

The Retro-Processing Contractor will return the request without action if none of the dates of the revised ESRD status are within the 36 months prior to the request.

The Retro-Processing Contractor will return the request without action if the beneficiary was not a member of the plan during the discrepancy period.

The Retro-Processing Contractor will return the request without actions if ESRD status is already reflected for the discrepancy period.

The Retro-Processing Contractor will take appropriate actions such as resync the systems to make the adjustment, or forward the request to CO, Managed Care staff.

The CO Managed Care staff will review and make note of any programmatic problems or trends that could be system related. The cases are then forwarded to OCSQ for manual input and update.

Tab G

PROCESSING OF WORKING AGED RETROACTIVE ADJUSTMENTS

Health Status Description

A beneficiary, who has Part A, receives the working aged status when the beneficiary or their spouse is employed and the beneficiary receives medical benefits from the employer. The employers medical insurance pays as the primary insurer and Medicare pays as the secondary payer (MSP), therefore the capitation rate is less than the normal Medicare rate. Additionally, some situations occur when Medicare is not the primary insurer, but these are incident related and do not effect the beneficiary's status. For specific criteria for Medicare to be the Secondary Payer, refer to Intermediary Manual Section 3491.

General Information about the Working Aged Payment Process and General Guidelines for all transactions

The primary sources of the information are the Social Security Administration/IRS Data Match, the Initial Enrollment Questionnaire that the beneficiary completes when first eligible for Medicare, the beneficiary's employer insurance company, the beneficiary themselves, the M+CO enrollment application or annual survey.

The M+CO is responsible for obtaining the most accurate information possible concerning the working aged status of the beneficiary. There are a variety of sources that the M+CO should use to validate the beneficiary's working aged status. These include:

- A survey that M+COs require beneficiaries to complete annually
- MSP screens shown in the CMS' Common Working File
- Data provided by the insurance company providing primary coverage,
- Data provided by the beneficiary's employer etc.

A copy of the survey is attached. (If an M+CO chooses to develop their own Working Aged Survey, it must be approved by the appropriate CMS Regional Office).

Once the M+CO has validated the working aged start and stop dates, the M+CO submits working aged transactions to the CMS via electronic transfer using the CMS' Managed Care On-line System (McCoy) or CMS' vendor, Acxiom Computer Services.

Through an automated process, the CMS systems edit the transactions to ensure that all fields are completed and match the beneficiary data residing in the Group Health Plan System (GHP). Incorrect transactions are rejected and returned to the M+CO with a code "U" (unacceptable) via McCoy or the Working Aged Status Report, a TSO monthly report. The M+CO must correct and resubmit these transactions. Acceptable transactions are forwarded to General Health Inc. (GHI), a contractor who has been retained by CMS to validate the working aged information and submit the data to the CMS' Common Working File. (GHI can be contacted at 1-800-999-1118). GHI reviews each transaction to ensure that the M+CO has the authority to make the change; the

beneficiary meets the working aged requirements, etc. If the termination date is within six months of the date that the SSA/IRS data match transaction occurred, the M+CO cannot submit a change. The M+CO can determine this by reviewing the transaction reply report.

The CMS Common Working File (CWF) transmits the working aged status to the CMS' managed care payment systems monthly.

Each working aged transaction submitted electronically by an M+CO receives a status. Possible statuses received for plan-submitted working aged transactions in McCoy are: N, U, G, S, P, A and R. Please refer to the Plan Communications Users Guide for a description of these status codes. Statuses of all transactions submitted appear in the McCOY Working Aged screens, and the Working Aged Transaction Status Report.

Documentation required to place a beneficiary in working aged status

Beneficiary Name

Health Insurance Claim Number

Source of working aged period includes one or more of the following:

- Survey completed by the beneficiary
- Initial Enrollment Questionnaire
- Document reflecting insurance coverage from an employer, insurance company etc.
- Record of telephone conversation with the individual, employer or insurer that includes:
  - Beneficiary's Name
  - Beneficiary's Health Insurance Claim Number
  - Date of conversation
  - Person contacted
  - Relationship to the beneficiary
  - Date insurance coverage began
  - Date insurance coverage terminated
- Access to a copy of the Working Aged HUSP record that is submitted through McCoy (Reference Plan Communication Guide Appendix C: Record Layouts)

General Guidelines for M+COs processing working aged adjustments

M+COs may enter working aged status adjustments for any period of time.

Payment will be limited to the 36 months previous to the system interface date, which is the date the transaction is processed in GHP for payment. This may be as long as 2 months after the M+CO enters the transaction into McCOY or submits the request to GHI.

The M+CO should never submit duplicate working aged transactions unless the CMS Central Office, Regional Office or Retro-Processing Contractor specifically requests that the duplicate information be submitted.

To follow up on specific previously submitted adjustments, a letter of inquiry should be sent separately from other adjustment requests. It should clearly state in the subject line that it is a follow-up to request(s) previously submitted. The letter must include the claim number of the individual, the health status, the period involved and the date the original adjustment(s) was submitted.

Retro-Processing Contractor Review and Processing of the Request

The Retro-Processing Contractor does not have a role in processing Working Aged transactions.

Any requests related to Working Aged adjustments received by the RO or the Retro-processing Contractor, will be forwarded to the appropriate DEPO Health Insurance Specialist for your RO.

Sources provided to M+CO's to assist with the updating of Working Aged are accesssable through the CMS Web site at http://cms.hhs.gov/healthplans/systems